# CHAPTER 3

## New Jersey's Strategic Priorities

The U.S. *Administration on Aging Strategic Plan, 2003-2008* lists five priorities that are intended to guide AoA's activities over the next five years. New Jersey has incorporated these same five priorities into the *New Jersey Strategic Plan on Aging, 2005-2008*, including the priority related to promoting effective and responsive management. Details appear below pertaining to the goals, objectives, strategies, and performance measures related to each priority.

### PRIORITY 1: Make it easier for older people to access an integrated array of health and social supports.

#### TRENDS AND CONDITIONS

There are presently two separate service delivery systems in New Jersey, one for older adults and one for people with disabilities. This situation is neither consumer-friendly nor cost-effective.

For consumers, the current system is frustrating, requiring them to go through many doors to obtain information, assess needs and, finally, receive services. This compartmentalization for accessing the system and determining eligibility for services is clearly not consumer-driven. From a governance perspective, there is no single entity at the state or local level that has the authority to coordinate awareness, assistance, and access to the full range of health and community services for long-term care support.

New Jersey's challenge is to unite the aging and disability networks so that the system covers the entire adult lifespan, facilitates continuity of care and services, and empowers consumers to control their own lives. In order to accomplish this, the State must redesign access to New Jersey's aging and disability long-term care support system to enable older adults and adults with physical disabilities to age in place.

#### GOAL 1: Establish an Aging and Disability Resource Connection (ADRC) in two counties and lay the foundation for statewide implementation.

#### ADRC GRANT

The Department of Health and Senior Services (DHSS), in collaboration with the Department of Human Services (DHS), was awarded an ADRC grant from the AOA and the CMS in 2003. This grant is part of the president's New Freedom Initiative, which aims at overcoming barriers to community living for older adults and people with disabilities and integrating long-term care resources for consumers into a single coordinated system.

DACS is collaborating with DHS's Division of Disability Services (DDS) and the Division of Medical Assistance and Health Services (DMAHS) on this three-year initiative. The purpose of this effort to redesign the State's aging and disability service delivery systems is to:

- Address the changing needs of older adults, people with physical disabilities, and their caregivers, including those from culturally diverse population groups and at all income levels.
- Support those in need of care and their caregivers across the lifespan.
- Empower individuals to make informed quality of life choices.
- Foster viable, affordable and cost-effective options for long-term care support services.
- Ensure a high-quality service delivery system that is visible, trusted and easy to access for both information and assistance.

The redesign of the long-term care delivery system requires both a systematic and cultural approach to change how New Jersey's government entities and their provider partners reach out to consumers, educate them about the full range of public and private community resources, and support them to make quality-of-life choices and access public long-term support programs. Long-term care services are targeted at persons 60 and older and persons 18 years and older who have physical disabilities.

## ADRC OBJECTIVES

1. Establish an effective organizational structure for the ADRC project.
2. Establish two ADRC pilot projects to serve as sole sources for home and community-based services.
3. Develop and implement new strategies for making ADRCs more visible, trusted, and consumer-friendly.
4. Become the gateway to programs that connect consumers to basic human need resources.
5. Re-engineer the long-term care financial eligibility and pre-admission screening infrastructure in order to achieve fast track eligibility.
6. Design, develop, and test a management information system that supports client-tracking, needs assessment, care plans, utilization, and costs of services. *(See Priority 5 for more detailed plans, re: management information systems).*

## ADRC FRAMEWORK

1. An *ADRC State Management Team* is comprised of 13 administrators, directors, and assistant commissioners from DACS, DDS, and DMAHS. It meets monthly to provide leadership and guidance in the development and implementation of ADRC. The project director apprises the *State Management Team* about the grant's progress and any issues that may impact how their programs interface with the ADRC.

2. Pilot Projects: Members of the *Systems Change Advisory Council* in New Jersey include a broad array of stakeholders. A subcommittee of this council developed an RFP and disseminated it to all 21 AAAs, inviting proposals to become a pilot ADRC site. This competitive process was deemed the most likely to assure the selection of two AAAs best suited for this initiative and most committed to succeeding. In April 2004, the RFP subcommittee selected the Atlantic County Division of Intergenerational Services and the Warren County Office on Aging as the two ADRC pilot projects.

3. Presentations: The ADRC project director, along with the director of DDS, made numerous presentations to statewide associations to fully apprise them of the initiative and enlist their participation in the development of the ADRC model. These organizations included the Association of Area Agencies on Aging (NJ4A), the County Welfare Directors Association, the Association of Disability Directors, the Association of Centers for Independent Living, the Association of Senior Center Directors, and the New Jersey Commission on Aging.

4. Formation of Workgroups: Eleven ADRC workgroups were established to specifically perform the research and development components of the ADRC model. The workgroups are charged with researching other State models that may be applicable to New Jersey and developing products such as a benefits screening tool, clinical assessment, etc.

   The workgroups are as follows: Benefits Screening, Clinical Eligibility, Financial Eligibility, Customer Excellence, Cultural Competence, Consumer Direction, NJ 2-1-1 Coordination, Public Awareness, MIS, Website Development, and SHIP Alignment. Co-leaders of each workgroup consist of staff from the aging, Medicaid, and disability networks. The collective membership of these workgroups consists of approximately 210 persons representing consumers and professionals from the aging and disabled networks.

5. Public Awareness Communications Plan: To help promote the ADRC, a *Public Awareness Communications Workgroup* was formed with membership from DACS, DDS, the two pilot counties, and other members of the community who volunteered through their County Offices on Aging and/or Disability Services for this function. The workgroup's charge is to: **(a)** identify and expand ways to reach consumers, and **(b)** clearly communicate with consumers so they know where to get answers.

   To gauge current public awareness practices and capabilities, the workgroup surveyed providers of aging and disability services statewide and in the two pilot counties and held focus groups with providers and consumers. A comprehensive marketing plan was developed based on the results of this research. Public awareness goals and key messages were developed, and the workgroup, in cooperation with the pilot counties, will produce numerous communication tools for use in promoting the ADRCs.

### Communications Plan Objectives

1. Ensure that the ADRCs are visible, trusted, and consumer-friendly.
2. Ensure that seniors, adults with physical disabilities, caregivers, service providers, referral agents, and members of the general public know that the centers exist, what they do, and how to contact them for information and services.

### Key Communications Messages

1. Seniors, adults with a physical disability and their caregivers residing in Atlantic or Warren Counties now have a single, shared place to go to and one simple number to remember and call, 2-1-1, to learn about and access home and community-based care.
2. ADRCs provide comprehensive information and assistance from caring, trained, and knowledgeable staff to persons seeking alternatives to nursing home care.
3. Users of the ADRCs will find the experience a positive one as their care options are fully explained and, when possible, connections to services are made.

### Communications Tools

1. Develop a project logo and tag line.
2. Print brochures, posters, specialty items, and other campaign materials.
3. Direct mail to targeted agencies and organizations containing information on the ADRC and an order sheet for speakers and/or additional printed materials.
4. Develop talking points and a PowerPoint presentation so that any staff member or volunteer could speak authoritatively on the ADRC.
5. Develop and publicize newspaper ads and public service announcements for radio and cable television stations.
6. Issue press releases to announce the launch of ADRC in both counties and to mark milestones and success stories.

## 6. ADRC Client Pathway Model

**Algorithm:** An algorithm for the ADRC model in New Jersey was developed to identify, define, and outline the client pathway (see Exhibit 2) and decision-making process for determining clinical and financial eligibility and accessing information. The model targets older adults, persons with physical disabilities, and their caregivers. It consists of these six-steps:

1. Build organizational infrastructure.
2. Initiate contact with consumers.
3. Identify consumer needs.
4. Indicate consumer choices through counseling.
5. Implement consumer directed care plans.
6. Inquire about program effectiveness through continuous quality improvement.

**Guiding Principles:** Incorporated into the ADRC Client Pathway model are three guiding principles: customer excellence, cultural competence and consumer direction.

**Atlantic County:** The *ADRC Project Team* is working simultaneously with each county on different components of the ADRC Client Pathway. In Atlantic County, the focus has centered on the "Initiate and Identify" steps of the Client Pathway. Activities include:

- Improving the working relationship with the disability network, specifically the Center for Independent Living.
- Implementing the 2-1-1 system for Atlantic County. The Atlantic Division of Intergenerational Services recently became the designated 2-1-1 agency for Atlantic and Cape May counties.
- Providing AIRS (Alliance of Information & Referral Services) certification training for Information and Referral staff of all key partners.
- Streamlining the Medicaid financial eligibility process.
- Testing a benefit screening tool and consolidated application for LTC supportive services.
- Building a more effective working relationship with culturally diverse communities, specifically developing a culturally competency training, performance standards and indicators.

**Warren County:** In Warren County, the focus has centered on the "Identify, Indicate and Implement" steps of the Client Pathway. Activities include:

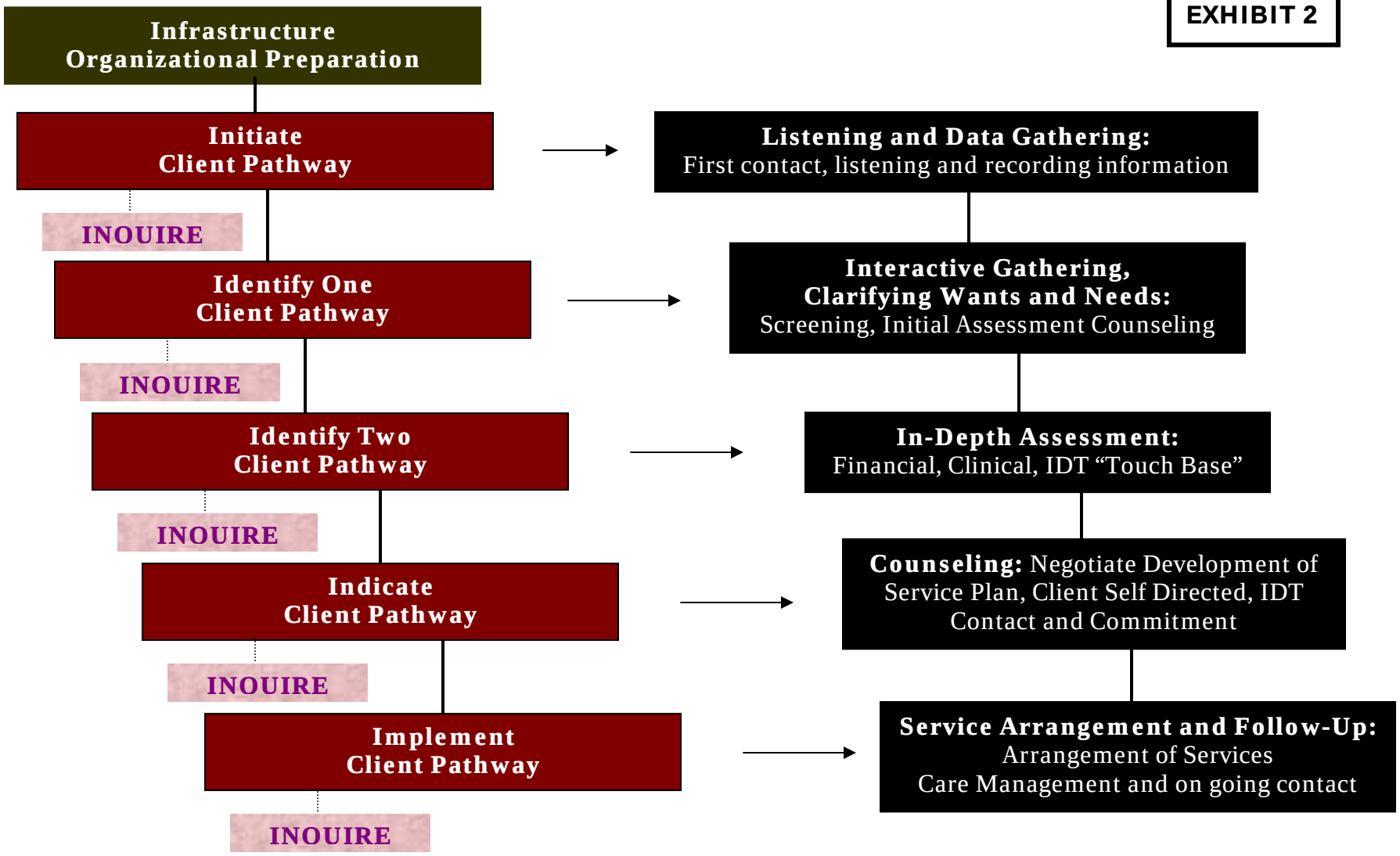
- Pilot testing the in-depth clinical assessment tool that will be used by the aging and disabled networks. The clinical assessment tool will be linked to levels of care, which incorporates consumer's expressed needs and wants.
- Developing an interdisciplinary team approach.
- Developing policies/protocols for in-depth assessments for all State and Federally funded aging and disability LTC programs.
- Testing protocols for finalizing and authorizing publicly funded services.

## PERFORMANCE MEASURES

New Jersey has adopted an ADRC Evaluation Plan to provide a framework for assessing implementation of the six ADRC grant objectives and to validate the ADRC Algorithm – Client Pathway Model. A systems model that focuses on input (system resources, policies, and protocols), throughput (program activities focusing on clients, staff, resource availability, adequacy of resources) and output (initial impact on clients, staff effectiveness, and process effectiveness) serves as the basis for the evaluation approach. Triangulation of evidence will be used including quantitative, qualitative and anecdotal data. The initial focus is on process evaluation in order to ensure that all performance indicators have been defined and to assess system change processes.

# ADRC Model: Concept & Client Pathway

**EXHIBIT 2**



## GOAL 2: Prepare Medicare counselors and others in the aging network for the launch of Medicare Part D, the new prescription drug benefit.

## TRENDS AND CONDITIONS

The Medicare Modernization Act of 2003 (MMA) includes a provision creating Medicare Part D, a new prescription drug benefit in the Medicare program. Throughout the coming year, 1.2 million people with Medicare in New Jersey need to be educated about the new prescription benefit and, if appropriate, will need help enrolling in a plan that best meets their needs. Additionally, many people with Medicare in New Jersey will be eligible for financial assistance to help pay the prescription plan monthly premium, annual deductible, and co-payments.

Under Medicare Part D, different subsidies will be available based on income and resources. Some people will not have to apply for the subsidy while others will be required to complete a lengthy application. All people with Medicare and Medicaid will lose their Medicaid prescription coverage at the end of the calendar year and will have to be enrolled in a Medicare Prescription Drug plan effective January 1, 2006.

People enrolled in New Jersey's Pharmaceutical Assistance to the Aged and Disabled Program (PAAD) will have to be educated about how Part D and PAAD will work together and the necessity that they enroll in Medicare Part D. People with a prescription benefit through an employer group health plan may lose the benefit and have to enroll in a Medicare plan, or they may have to decide between keeping the employer benefit or enrolling in a Medicare plan.

## OBJECTIVES (MEDICARE PART D)

1. Provide information and assistance to a greater number of Medicare beneficiaries unable to access other channels of information or needing and preferring locally based individual services.
2. Increase targeted outreach in order to provide access to information to low-income, dually-eligible, and hard-to-reach populations.
3. Develop partnerships with community-based organizations/service agencies and enhance the SHIP counselor cadre and equip them to be proficient in the education of and assistance to people with Medicare with regard to the Medicare prescription drug benefit.

## STRATEGY

1. Offer educational seminars to professionals and providers within the aging and disabled networks about the Medicare prescription drug benefit and low-income subsidies.
2. Offer educational seminars to people with Medicare in every county in New Jersey.
3. Provide additional hours of training to SHIP counselors statewide with regard to the Medicare prescription drug benefit.

4. Collaborate closely with CMS, Social Security Administration, and the AoA as an active partner to provide the most current and accurate information to beneficiaries and assist them in applying for the low-income subsidy.
5. Identify and partner with organizations/agencies that provide services and assistance to low-income, dually-eligible, and hard-to-reach people with Medicare.
6. Participate in the New Jersey Consortium as a member of AoA's Medicare aging network. Share best practices and materials, avoid duplicative efforts, and enhance the collective ability of the group to reach the varied and diverse Medicare population in NJ.
7. Work closely with PAAD to (a) ensure that its beneficiaries enroll in a Medicare prescription drug plan that meets their needs, and (b) facilitate application for the low-income subsidy available to approximately one-third of PAAD enrollees.
8. Increase the number of local sites where people with Medicare can obtain necessary Medicare prescription plan information and help with enrollment.

## PERFORMANCE MEASURES

DACS's degree of success will be measured by the numbers of people reached through outreach events and one-on-one counseling with essential information -- as compared to the total number of people with Medicare in New Jersey. Enrollment data from the CMS will indicate the number of people who actually enroll in a Medicare prescription drug plan in the required time frames (i.e. 12/31/05 for dually eligible individuals and 5/15/06 all others).

## GOAL 3: Ensure that DACS and its partners in the aging and disability network attain cultural and linguistic competence in order to better serve New Jersey's growing diverse population.

## TRENDS AND CONDITIONS

Cultural and linguistic competence has been identified by DACS as a guiding principle applicable to all of the work done by the Division. Cultural and linguistic competence is defined as the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. The incorporation of cultural and linguistic competence in program administration and service delivery will likely increase service access, consumer and family satisfaction, and improved client/service outcomes.

Communities in New Jersey have become more racially, ethnically, and culturally diverse. According to statistics from the New Jersey Office of Minority and Multicultural Health, the African American community represents 13.6% of the State's total population (1,141,821); Hispanic or Latino Americans represent 13.3% of the total population (1,117,191); and Asian Americans represent about 5.7% of the total population (480,276). This represents about one-third of the State's total population.

Within each of these population groups there is tremendous diversity among ethnicities and languages spoken (70+ languages are spoken in New Jersey). Minority older adults access aging services at lower rates than their white counterparts. It is a significant challenge for social service and health care providers to meet the needs of such a diverse population.

## OBJECTIVES

1. Develop a Cultural Competency Model that will address issues of access, cultural competence, and linguistic competence and contain specific indicators with related outcomes.
2. Continue to identify key players within diverse communities to begin to establish dialogue and trust within these communities.
3. Increase the Division's capacity to contract with potential minority providers (providers whose client base is 51% minority or higher).
4. Continue to develop a training program that promotes cultural competence among DACS staff and all contracted providers across existing community programs.

## STRATEGY

1. Pilot test the Cultural Competency Model at DACS as well as in Atlantic and Warren Counties, the ADRC pilot sites.
2. Recruit and train volunteers from community-based and faith-based organizations to become *Community Ambassadors* responsible for sharing key information from DACS with their communities. These leaders can assist the Cultural Competency Subcommittee in the design and implementation of culturally appropriate services.
3. Offer grant-writing workshops for grassroots organizations identified in partnership with the Office of Minority & Multicultural Health, Office of Faith-Based Initiatives, Center for Hispanic Policy, and the like.
4. Develop a cultural competence training curriculum for DACS staff and contracted providers.

## PERFORMANCE MEASURES

1. Organizational self-assessment tool and cultural competency plan.
2. Multicultural coalition of key leaders.
3. Number of workshops, number of actual contracted providers.
4. Annual training plan, number of organizations trained, number of professionals trained.

## GOAL 4: Ensure consumer direction throughout the aging services network and implement New Jersey's *Promoting Consumer Direction in Aging Services* grant.

## PROMOTING CONSUMER DIRECTION IN AGING SERVICES GRANT

DACS was one of the five grantees in 2004 to be awarded a *Promoting Consumer Direction in Aging Services* grant funded by the National Council on Aging (NCOA) and the National Association of State Units on Aging (NASUA). The purpose of the grant is to support States' efforts to assess their home and community-based service systems and to identify opportunities to increase consumer choice and control (NCOA and NASUA, 2003).

In combination with this grant, DHSS pooled together resources from its ADRC grant and the Division of Disability Services' *Real Choice Systems Change* grant to identify opportunities of consumer choice and autonomy. A *Consumer Direction Advisory Task Force* was established to oversee the activities of the *Promoting Consumer Direction in Aging Services* grant.

The task force's specific goals were to implement the consumer direction tool in a statewide effort, conduct focus groups regarding the topic of consumer direction, host one public forum with key stakeholders, and produce a report summarizing its activities. The report reflects all of the activities, findings from the survey and focus groups, as well as a proposed plan designed by the key stakeholders who attended the public forum. The report also recommends "Next Steps" for integrating consumer direction into New Jersey's aging and disability networks.

## TRENDS AND CONDITIONS

Several overarching issues became apparent from the surveys and the focus groups and these were addressed during the public forum. Ultimately, the key stakeholders who participated in the surveys, the focus groups, and/or the public forum identified productive steps to take to remove barriers that currently hinder consumer choice and autonomy. Among these were the following:

- More training is needed for all participants in the provision of long-term care and support services in terms of consumer direction.
- Consumers need to be educated about the range of decision-making that they have in their care plan and the responsibilities that exist in direction of their own care.
- Consumers would further benefit if front line workers received more training in communication, especially in terms of how to engage consumers in planning the care they want.

The communication skills of case managers and care coordinators are not the only impediment to the provision of consumer direction in care planning and service implementation. Another key issue is the complicated structure of types of services and their funding sources. Therefore, key stakeholders requested that service policies should be more streamlined so that when a consumer identifies the different types of assistance she or he would like to get, those services

are available regardless of funding source. That would do away with the issue of waiver slots being available and thereby remove limits on the types of services that a consumer can receive.

Finally, key stakeholders suggested that more entities work together, especially in terms of different State departments and divisions combining their resources and policies to better serve people who prefer to remain in or return to the community. The development of such collaborative relationships also includes the State and consumers engaging with private industries and organizations to design and build infrastructures that support people with disabilities of all ages who want to live and work in the community.

## GRANT DELIVERABLES

1. Establish an advisory committee and hold a minimum of five meetings.
2. Use the *Consumer Direction Tool* developed by NASUA/NCOA to assess program policies that promote or hinder consumer direction.
3. Sponsor at least one focus group to ensure key stakeholder input.
4. Sponsor at least one public forum to ensure key stakeholder participation.

## KEY FINDINGS

There were five overarching areas that emerged from the *Consumer Direction Tool* responses and the focus group statements. These areas are:

- Autonomy and independence
- Communication and information
- Workforce/status of the care workers
- Medical model
- Employment

These five themes were presented at a public forum on January 11, 2005. Public Forum attendees were organized into breakout sessions with each group representing one of the themes. Each breakout session was charged with developing an action plan to further develop consumer direction principles in the policy design and program implementation of long-term support services. (See *New Jersey's Road Map to Consumer Direction*, Exhibits 3-7).

## RECOMMENDATIONS

There are several general steps that the key stakeholders recommended relating to training, improving communication opportunities, and streamlining long-term care and support policies. More specifically they are as follows:

- All providers of long-term care and support services need consumer direction training. Consumers also need to be educated about the range of decision-making they may have in relation to their care plan and the responsibilities that exist in directing their own care.
- Front line workers need training in communication skills, especially focused on engaging consumers in planning the care they want.
- The complex structure of funding sources is another issue. Key stakeholders requested that policies be streamlined so that services are available regardless of the funding source.
- Entities should work together to promote consumer direction. Different state departments and divisions should combine resources and policies to better serve people who prefer to remain in or return to the community.
- The state and consumers should work with private industry and community organizations to design and build infrastructures that support people with disabilities of all ages who want to live and work in the community.

## SHORT-TERM GOALS

1. Develop and provide consumer direction training for:
   - Leadership
   - Professionals
   - Front-Line Workers

2. Consumers want and need consumer direction training
   - Atlantic and Warren County Centers for Independent Living (CILS) will provide training to consumers

3. Develop web-based "Self-Assessment" tool

## LONG-TERM GOALS

1. Streamlined policies - regardless of funding streams. Government agencies, counties and private industry work collaboratively.

## PERFORMANCE MEASURES

DACS will implement the strategies outlined in *New Jersey's Road Map to Consumer Direction* in order to achieve the desired outcomes and increase consumer direction in New Jersey.

# New Jersey's Road Map to Consumer Direction

**EXHIBIT 3**

## Autonomy & Independence

| GOAL | STRATEGY | PARTNERS | OUTCOMES |
|---|---|---|---|
| Establish accessible, affordable, safe housing | Link the development of housing and transportation<br><br>Explore private/volunteer transportation options<br><br>Housing subsidies be attributed to person, not housing location<br><br>Remove age restrictions in senior housing so younger adults can live in and take care of older adults | Developers, legislators, banks, planning boards, Housing and Urban Development agencies (HUD), large employers, Housing Mortgage Finance Association. | Consumers would have choices which support autonomy and independence<br><br>Accessible and integrated communities |
| Enable consumers to be informed about all options (care) | Involve hospital and nursing home discharge planners<br><br>Develop and provide a self-assessment tool for autonomy<br><br>Develop and provide a checklist regarding level of independence<br><br>Develop public relations campaign - design brochures re: description of independence required for levels of care<br><br>Public relations work continues with the use of billboards | Information and assistance, single-point-of-entry workers and managers, all NJ EASE partners/AAA, Boards of Social Services, hospital discharge planners, nursing home discharge planners, AARP, senior centers, senior villages, doctors' offices, churches, rehabilitation centers, home health providers | Informed consumers who are able to make choices and who are provided with assistance before crises occur or worsens.<br><br>People-centered information and assistance programs. |

# New Jersey's Road Map to Consumer Direction

**EXHIBIT 4**

## Communication and Independence

| GOAL | STRATEGY | PARTNERS | OUTCOMES |
|---|---|---|---|
| Improve clarity of information | Attach to licensures/certifications<br><br>Advertise on buses – print ads – Use simple language (doctor's offices, health providers, etc.)<br><br>One phone number as point of entry; | Social Security, Hospital Social Workers/ discharge planners, Home Health Agencies/VNAs, Medical Society, Hospital Association, AARP (newsletter), municipalities, Employers (for notices /information distribution with check), bulletin boards, Banks | |
| Improve the eligibility process | Use NJ Helps; Create/utilize web-based information<br><br>Link the State home page to the benefits screening tool (NJ Helps)<br><br>Mail out the "required documentation" brochure | State/county program entities | Consumer takes more responsibility for completing the application<br><br>Reduces burden of the in-take worker<br><br>Reduces time caregiver has to take off work to handle the paperwork issues |
| Enhance interpersonal skills | Develop educational programs for professionals to improve interpersonal communication skills – "what do you want me to do for you?"<br><br>Address issues of automated systems (for some, can't follow the menu, can't hear, etc) | State staff | Consumer Direction will become integral component of service delivery<br><br>Increase intranet messages; enhance websites with simple links |

# New Jersey's Road Map to Consumer Direction

**EXHIBIT 5**

## Status of the Care Worker

| GOAL | STRATEGY | PARTNERS | OUTCOMES |
|---|---|---|---|
| Establish better communication and to share information | Educate workers and consumers regarding consumer direction and develop websites regarding programs<br><br>Survey former aides to determine why they left and what could have improved their employment situation | Home health care associations, the Board of Nursing, advocacy groups, and employment offices | To have more workers remain in the field; to have more flexibility in terms of activities that home health aides can perform (such as walking in the park with their client); and to have reimbursement for travel in addition to other improved benefits |
| Engage more consumers involved in advocating for improved workers' status | | Same as above | Same as above |
| Elevate the status of care workers | Explore what other states do and to use a state's (or multiple states) regulations as a model in changing regulations associated with care workers | Same as above | Same as above |
| Evaluate regulations that oversee workers | Advocate for changes in the Nurse practice Act<br><br>Have the home care industry and the Board of Nursing work together on developing policies | Same as above | Same as above |

# New Jersey's Road Map to Consumer Direction

**EXHIBIT 6**

## Medical Model

| GOAL | STRATEGY | PARTNERS | OUTCOMES |
|---|---|---|---|
| Take a holistic approach in working with consumers | Have customized services that are driven by consumers' needs | Consumers, AAA's, County Offices of Disabilities, Boards of Social Services, Independent Living Centers, medical providers, community based service providers/ home health care agencies | The consumer maintains her or his dignity and to receive services as requested |
| Create an environment that prevents crisis situations | Change regulations that prohibit flexibility of workers' activities so that regulations allow for more focus on prevention of crises rather than the reactionary process that now occurs | Same as above | Same as above |
| Provide uniform options for consumers | Educate consumers and providers in terms of consumer direction. Streamline the application process. | Same as above | Same as above |
| Have the global budget provide a holistic approach | Have customized services that are driven by consumers' needs | Same as above | Same as above |

# New Jersey's Road Map to Consumer Direction

**EXHIBIT 7**

## Employment

| GOAL | STRATEGY | PARTNERS | OUTCOMES |
|---|---|---|---|
| Improve transportation options for people with disabilities | Training, cross-training and ongoing training | New Jersey WorkAbility program in the Division of Disability Services and DMAHS; Division of Vocational Rehabilitation; Department of Transportation; workforce investment boards, private sector organizations such as corporations, banks, financing entities and professional organizations; discharge planners at rehabilitation facilities and hospitals | More people returning to the workforce<br><br>Link state agencies with the disability community<br><br>Unify access to employment opportunities<br><br>Increase uniformity of service delivery |
| Disseminate more employment information to the general public | Publishing success stories;<br>Conduct education presentations | Same as above | More public awareness of the needs of people with disabilities and older adults |
| Improve access to employment information and referral services | Training, cross-training and ongoing training | Same as above | Same as above |
| Build disability coalition partners | Reaching out to the private sector | Same as the above | Same as above |

## GOAL 5: Work cooperatively with key players in the transportation sector to assess the need for, and improve the coordination of, transportation services for older adults.

## TRENDS AND CONDITIONS

The key players in New Jersey with regard to transportation services are the Department of Transportation, which operates New Jersey Transit, and DHS. DHSS also has a clear interest in transportation services because they are so essential for older adults, especially those who are low-income, frail/disabled, or vulnerable.

Although there is some cooperation among these and other agencies regarding transportation, there is also fragmentation of effort. In addition, transportation for older adults can be costly – both to individual riders and to the agencies that endeavor to pay for these services on their behalf. Last year in New Jersey, DACS served 15,825 clients with $5,578,370 through its transportation services. In addition, it served 6,869 clients with $917,166 through its assisted transportation services.

## KEY FINDINGS

**Public Input:** Participants at public hearings that were held in April and May 2005 to elicit input to this plan addressed transportation needs as follows:

- There are not enough vehicles to accommodate the homebound or for shopping.
- There is a need for transportation to take seniors to a senior center.
- There is a need for transportation for medical needs such as dialysis.
- There is a need for transportation for extended hours, e.g. weekends, evenings.
- Transportation is needed for short trips back and forth to the post office.
- Riding time is frequently too long.
- It's difficult to get into the van if it doesn't have a handicap ramp or lift.
- Scheduling transportation is difficult. For example, a person must call one week ahead for scheduling transportation, e.g. for medical needs

**AAA Transportation Services:** Listed below are just a few of many transportation-related efforts:

- **Bergen County:** Provides funds for an assisted transportation program.
- **Hunterdon County:** Funds and provides transportation services, including nominal cost transportation through the County's LINK program and door-to-door transportation through the Medicaid Sedan Service.
- **Morris County:** Provides assisted transportation and rides for nutrition programs, doctor's visits, and shopping.

## UNITED WE RIDE OBJECTIVES

DHSS partners with other agencies to achieve mutually beneficial results. Thus, it is a partner in the *United We Ride* initiative (UWR), which is primarily focused on improving the coordination of transportation services. NJ Transit is the lead agency responsible for the application, implementation, reporting, and evaluation process for the UWR grant because it is the State designated recipient and administrator for FTA grants and state casino revenue funds for transportation.

The project objectives of UWR are as follows:

1. NJ officials, agency directors, and human services program administrators will have an increased knowledge of the UWR Initiative.
2. Regulatory and administrative guidance will be written for UWR activity in NJ.
3. Baseline data will exist on all of the State agencies and programs that provide human service transportation in New Jersey.
4. An Action Plan for a *Statewide Assessment of Human Services Transportation* will be developed by NJ's UWR Interagency Committee.
5. A technological system(s) will be in place to track UWR project activity.
6. A centralized technological system will be identified for storing data on human services programs in New Jersey.

UWR grant funds will be used to conduct a maximum of four statewide seminars/ conferences on the UWR Initiative, disseminate information regarding the NJ UWR Initiative to all stakeholders, and administer expanded interagency coordination committee meetings, among other things.

## STRATEGY

**NJCAM:** DHSS is also a member of the New Jersey Council on Access and Mobility (NJCAM). NJCAM's charge is to:

1. Do an inventory of existing State and Federal transportation funding sources used for transportation service within 12 various departments/agencies in New Jersey.
2. Study ways to improve coordination of sources.
3. Make recommendations to the Governor and State Legislature.
4. Coordinate activities with the Federal Council on Access and Mobility.

## TOOLS

**AoA Toolkit:** Because New Jersey is committed to enhanced coordination of transportation services for older individuals, it looks forward to reviewing the AoA Transportation Toolkit, entitled *Senior Benefit from Transportation Partnerships – Case Studies from the Aging Network*, when it is disseminated in the near future. The toolkit will focus on assessing transportation needs as well as coordinating transportation services.

## OBJECTIVES

1. Utilize the AoA Transportation Toolkit to assess the transportation needs of aging and physically disabled individuals.
2. Participate actively in interagency efforts, such as *United We Ride*, to coordinate transportation services specifically in terms of the needs of older adults and adults with physical disabilities.
3. Explore best practice models in other States, including funding resources.

## PERFORMANCE MEASURES

DACS will utilize the AoA Toolkit to assess transportation needs and improve the coordination of transportation services.

## PRIORITY 2: Help older people to stay active and healthy.

## TRENDS AND CONDITIONS

**Life Expectancy:** The rapidly growing aging population, together with projections of continued increases in life expectancy and an increasingly diverse aging population, underscores the critical need to assist individuals to practice healthy behaviors and minimize the limitations of chronic disease. Average life expectancy has increased dramatically, from 47 years in 1900 to nearly 77 years in 2000. By 2030 the number of older Americans will more than double to 70 million, or one in every five Americans.[1] Approximately 80% of all persons aged 65 and older have at least one chronic condition, and 50% have at least two.[2] New Jersey is one of the most ethnically representative states in the nation, with more than 2 million New Jersey residents speaking a language other than English at home. Disparity in health status is evidenced by the 16-year difference in healthy life expectancy at birth between white females at 69.6 years, compared to African American males at 53.9 years.[3]

**Leading Causes of Death:** In New Jersey, as in the U.S., the leading causes of death are heart disease, cancer and stroke. Diabetes, influenza/pneumonia and unintentional injuries rank next among the leading causes of death for people age 55 and older.[4] Average per capita personal health care expenditures in New Jersey ($4,418) are higher than the U.S. average ($4,026).

---

[1] *Healthy Aging: Preventing Disease and Improving Quality of Life Among Older Americans*, 2002. Centers for Disease Control and Prevention.
[2] *Public Health and Aging: Trends in Aging --- United States and Worldwide*, *Morbidity and Mortality Weekly Report*, February 14, 2003 / 52(06); 101-106, Centers for Chronic Disease Control and Prevention.
[3] *Healthy Life Expectancy at Birth in Years, New Jersey, 1996-1998.* Center for State Health Statistics, http://nj.gov/health/chs/stats.
[4] *Leading Causes of Death by Age Group, New Jersey 2002,* Center for State Health Statistics, http://nj.gov/health/chs/stats02/mort02.pdf#m1.

**Chronic Conditions:** Most chronic conditions are not a natural part of the aging process and can be prevented. Research has shown that information on healthy practices leading to chronic disease self-management has powerful effects on health and quality of life. While many older adults are aware of and intend to practice healthy behaviors, more than half say they are not always able to practice healthy behaviors, citing lack of motivation, money, time or access as major barriers[3]. In 2002, New Jersey failed to reach these four of the ten *Healthy People 2010* health objectives for older adult health: **(a)** physical activity, **(b)** overweight, **(c)** fruit and vegetable consumption, and **(d)** pneumonia vaccination.[5]

**Preventable Diseases:** In 2004, 69% of New Jersey residents 65 and older received flu shots and 63% received pneumonia shots. New Jersey adults aged 65 and older obtained screenings at a lower rate than the national average (75% of women had mammograms and only 56% of older adults had an annual sigmoidoscopy or colonoscopy screening).[4] Scientific evidence suggests that about one-third of the 570,000 cancer deaths expected to occur in 2005 will be related to nutrition, physical inactivity, overweight and obesity, and thus could be prevented. Regular screening examinations can detect cancers of the breast, colon, rectum, and prostate at early stages when treatment is more likely to be successful.[6]

**Falls:** More than one-third of older adults age 65 and older fall each year and about 30% of these individuals suffer injuries that can decrease mobility and independence. In New Jersey, deaths from falls are the second-leading cause of unintentional injury deaths among the elderly, after motor vehicle related fatalities. Of all deaths of New Jerseyans from falls, about 70% occur among persons 65 and older, with the population 85 and over experiencing the greatest impact.[7] Of all non-fatal injuries, hip fracture is the most serious for older adults. In New Jersey there are about 8,000 hip fractures in individuals 65 and older annually[8], a number expected to grow as the population ages. People with osteoporosis are at increased risk of hip fracture. Over 900,000 New Jersey residents had osteoporosis or low bone mass (osteopenia) in 1996, and the estimated medical cost of osteoporosis in 2000 was over $496 million.[9]

**Arthritis:** Arthritis is the State's leading cause of disability, affecting over 2.5 million people[10] at an annual cost of over $3 billion in medical care and lost productivity[11]. The incidence of

---

[5] The State of Aging and Health in America, Merck Institute of Aging & Health and the Gerontological Society of America, 2003.

[6] American Cancer Society, Cancer Facts and Figures 2005.

[7] Healthy New Jersey 2010, A Health Agenda for the First Decade of the New Millennium, New Jersey Department of Health and Senior Services, 1999.

[8] Injury Prevention and Control White paper, NJ Department of Health and Senior Services

[9] *The Cost of osteoporosis in New Jersey: Projections for 2000-2005,* Burge et al., Procter & Gamble Pharm, 2001.

[10] *Behavioral Risk Factor Surveillance Survey, 2001.* Centers for Disease Control and Prevention.

[11] *Direct and Indirect Costs of Arthritis and Other Rheumatic Conditions --- United States, 199, Morbidity and Mortality Weekly Report*, November 21, 2003 / 52(46);1124-1127. Cisternas, et al.

arthritis increases with age; by age 65, nearly 60% have some type of arthritis.[12] With the aging baby boomers remaining in the workforce, arthritis as a public health issue is expected to reach epic proportions.

**Health Literacy:** Low health literacy has been identified as a primary factor for both poorer health status and lower service utilization. Nationally, two-thirds of adults age 60 and older have inadequate or marginal literacy skills, and 81% of patients age 60 and older are unable to read or understand basic medical information such as prescription labels. While low health literacy affects people of all races, ethnic backgrounds, income, and age (nearly 50% of all adults in the U.S. have difficulty understanding basic health information), it is more prevalent among older adults and those with limited proficiency in English. New Jersey's unique demographics, as well as the increasing complexities of the health care and social service delivery systems, make culturally and linguistically appropriate health literacy efforts a public health and aging priority.

**Obesity:** Research indicates that the continuing epidemic in obesity among all ages can reduce length of life by 5 to 20 years,[13] yet few older adults engage in recommended levels of physical activity and significant numbers do not engage in any physical activity at all. Fewer than 20% of New Jersey residents aged 55-64 and 10% of residents aged 65 and older meet recommended guidelines for vigorous physical activity (30 minutes or more of activity five or more days per week). In addition, 60% of the 55-64 age group and 66% of the 65+ group report no physical activity at all.[14] Nationally, NJ ranks 8th in the number of obese older adults (16.3%). Only one-third of those aged 65 and older consume 5 or more fruits and vegetables daily.[4]

**Minimizing Chronic Disease and Maximizing Quality of Life:** Increasing disease prevention and health promotion opportunities for older adults is one of the few avenues available to address the looming impact of chronic disease and other illnesses, disabling injuries, and long-term health care costs among older Americans. People who are physically active, eat a healthy diet, do not use tobacco, and practice other healthy behaviors, including appropriate health screenings, reduce their risk for chronic disease. They also have half the rate of disability of those who do not practice healthy behaviors.

**Physical Activity:** The single most important step that most adults, including older adults, can take to improve their overall health is to become more physically active.[15] Research

---

[12] *Portrait of the Chronically Ill in America,* 2001. Robert Wood Johnson Foundation and Foundation for Accountability (FACCT).

[13] *A Potential Decline in Life Expectancy in the U.S. in the 21st Century,* S Olshansky, et al., New England Journal of Medicine 352;11, 1138-1145, 2005.

[14] *Behavioral Risk Factor Surveillance System, New Jersey 2003,* Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. www.cdc.gov/brfss/.

[15] *Physical Activity and Health: A Report of the Surgeon General*. US Dept. of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 1996.

demonstrates the health benefits of increasing physical activity even among "old-old" adults.[16] As reported by the Surgeon General, "the body's response to physical activity and exercise has important positive effects on the musculoskeletal, cardiovascular, respiratory and endocrine systems."[17] The benefits of increasing physical activity among older adults also include: **(a)** reducing medical costs by as much as $77 billion annually[18]; **(b)** lowering the risk of premature death, high blood pressure, diabetes, some types of cancer; and **(c)** reducing depression. Long-term physical activity also helps postpone disability and increase the ability of even the 'oldest old' to live independently, including individuals with chronic disease.[19]

**Nutrition:** Since 1974, New Jersey's Senior Nutrition Program has been a valuable resource to older persons throughout the State. Providing both good nutrition and social engagement, the congregate and home delivered meal programs help adults aged 60 and older stay healthy, active, and independent. New Jersey's major demographic shifts (increased ethnic/racial diversity and an aging population) are having a significant impact on the nutrition program. In Summer 2004, DACS launched "Mission Nutrition" to assess the current program and set new directions to better meet the changing needs of the 60+ population. The Mission Nutrition Summit, held October 7 and 13, 2004, initiated the process of redefining the future directions of senior nutrition in New Jersey. Findings of the 2004 statewide survey and the review and assessment of focus group data offers baseline information to develop the overall strategy of re-defining the New Jersey Senior Nutrition Program.

**GOAL 1:** **Empower older adults to actively engage in healthy behaviors so they can live longer, maintain their quality of life, and participate in/contribute to their communities. Extend health, functional independence, and health-related quality of life as long as possible.**

**STRATEGY**

1. Support Healthy Lifestyle Behaviors

    a. Raise awareness among the health/aging provider networks and encourage delivery of evidence-based health promotion/disease prevention programs for older adults in areas such as nutrition, physical activity, cancer screenings, tobacco cessation, and influenza and pneumococcal vaccines.

---

[16] *The Aging States Project: Promoting Opportunities for Collaboration Between the Public Health and Aging Service Networks*. Chronic Disease Directors/National Association of State Units on Aging, 2003.
[17] *Physical Activity and Health: A report of the Surgeon General*. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition and Physical Activity. (2001). Department of Health and Human Services.
[18] *The State of Health and Aging in America 2004.* Merck Institute of Aging and Health and Centers for Disease Control, 2004.
[19] Spirduso, W. and Cronin, D. (2001). Exercise dose-response effects on quality of life and independent living in older adults. *Medicine and Science in Sports and Exercise Supp: Dose Response issues concerning physical activity and health: An evidence based symposium*, **33(6)**, S530-S550.

b. Promote educational programs for providers and older adults on healthy lifestyle, chronic disease management and risk factor reduction.
c. Expand the infrastructure/capacity for a range of evidence-based physical activity programs statewide, including: Live Long, Live Well Walking Program, Project Healthy Bones exercise and education program for people with or at risk of osteoporosis, Arthritis Quality of Life Programs (PACE – People with Arthritis Can Exercise, AFAP – Arthritis Foundation Aquatic Program, T'ai Chi for People with Arthritis), and HealthEASE Exercise Program. Particular focus will be on recruiting and training physical activity leaders from targeted ethnically/culturally diverse communities.
d. Promote self-efficacy and ensure statewide availability of the HealthEASE education program, the expansion of Chronic Disease Self Management Programs and the Arthritis Self-Help Course utilizing the ADRCs and health/aging provider networks.
e. Reduce the overall morbidity and mortality related to falls through the development and dissemination of fall prevention brochures; a web-based fall-injury module available on the division's health promotion web site; technical assistance on in-home fall prevention technology for health and aging networks, and provision of in-service education to nursing home transition teams to assist in the transfer of elderly nursing home residents to community settings.
f. Collaborate with disease management programs within the Department of Health and Senior Services to support initiatives in areas such as cancer, diabetes, cardiovascular disease and immunization.

2. Strengthen the Relationship Among Public Health and Aging Networks

a. Implement evidence-based health promotion and disease prevention programs, including influenza and pneumonia vaccination clinics. Public awareness campaigns, developed by the NJ Communicable Disease Service Program, will be expanded to include a partnership with county offices on aging and aging provider networks. Flu clinics will be coordinated with other major senior wellness events through collaboration with the NJ Influenza Advisory Committee.
b. Integrate DACS' principles, goals and strategies for improving/maintaining older adult health and wellness as key components in the New Jersey Public Health Practice Standards for local and county public health departments; provide best practice examples/standards for older adult health promotion/disease prevention initiatives.
c. Utilize the outcomes of the HealthEASE pilot project for coordinated health promotion/disease prevention to encourage local partnership.
d. Foster aging network collaboration with local public health departments as an element within Title IIID Policy. Broaden access to evidence-based older adult health promotion training/programs to local public health agencies.

3. Increase Health Literacy

    a. Ensure access to older adult health promotion and disease prevention activities for New Jersey's ethnically diverse population through a multi-year health literacy initiative that includes: **(1)** raising awareness of the importance of health literacy competency for public health and aging providers through delivery of a health literacy training curriculum; and **(2)** training a cadre of multidisciplinary health care professionals to deliver health literacy programs to community-dwelling older adults to build and improve their health literacy skills.

4. Increase Provider Knowledge About The Benefits of Evidence-Based Behavior Change Programs and Encourage Their Delivery

    a. Sponsor a statewide forum to: **(1)** educate providers on the availability and benefits of evidence based health promotion programs for older adults; **(2)** demonstrate the use of aging/health network partnerships to implement effective health promotion/disease prevention activities; and **(3)** implement a statewide evaluation tool to evaluate the reach, scope and effectiveness of older adult health promotion/disease prevention programs.

5. Review Title III D Fund Utilization and Current Policy

    a. DACS' policy for the OAA Health Promotion/Disease Prevention funds was written in 1993. Research throughout the past decade has resulted in the emergence of new strategies to best promote the health of older adults. To determine current practice, DACS will conduct an in-depth analysis of Title III D funds in the 21 AAAs. Then, in collaboration with a statewide ad hoc committee, the existing Title III D policy will be reviewed, revised, and reissued to reflect the most current trends and best practices.

## PERFORMANCE MEASURES

1. Delivery of a statewide forum on evidence-based programs for up to 150 local health and aging providers. Distribution of compendium of "turnkey" evidence-based health promotion programs to forum attendees and other potential providers.
2. Increased availability of evidence-based health promotion programs measured by attendance at leader training programs and requests for program materials.
3. Documentation of increased partnership role of AAA and aging providers in providing/coordinating older adult immunizations and health screenings.
4. Implementation of web-based fall-injury module on DACS' webpage. Promote utilization of webpage through aging, local public health and nursing home associations.
5. Inclusion of DACS' wellness principles in the NJ Public Health Standards for Older Adult Health Promotion/Disease Prevention.
6. Revision of DACS' policy for the administration of Title III D of the Older Americans Act.

**GOAL 2:** **Through Mission Nutrition, redefine the New Jersey Nutrition program as a full service community program, an integral component of a comprehensive and coordinated system of home and community based services.**

## STRATEGY

1. Establish a think tank of high-level representatives from private industry to advise DACS on innovative strategies for enhancing the senior nutrition program.
2. Strengthen the infrastructure of the senior nutrition program through ongoing forums for the nutrition program directors.
3. Conduct an analysis of current financial practices used in nutrition programs. Develop recommendations for improvement.
4. Implement pilot programs for innovative programming to better meet the diverse needs of the senior population. Utilize the pilots as statewide models.
5. Establish quality assurance measures for the Senior Nutrition Program.
6. Identify and collaborate with minority organizations to develop effective outreach methods that will increase the participation of target populations at senior nutrition centers, with emphasis on cultural and racial minorities.
7. Expand ethnic menus to provide appropriate meals for culturally diverse populations.
8. Expand programming at senior nutrition sites through community partnerships.
9. Establish new directions for senior nutrition emphasizing a variety of food selections such as salad/deli bars, fresh food alternatives, flexible menus, and new dining environments.
10. Expand health and wellness activities at senior nutrition sites, with a focus on evidence-based programs.

## PERFORMANCE MEASURES

1. Creation of Mission Nutrition “think tank” and establishment of ongoing methods for gathering input from this private sector panel.
2. Inclusion of quality assurance standards and improved financial practices in area plan contracts.
3. Increased participation of cultural and racial minorities in congregate and home delivered meal programs.
4. Attendance of nutrition program staff at evidence-based programs forum and participation in leader training programs.
5. Outcomes from pilot programs in expanded food selections (including ethnic menus).

## GOAL 3: Promote early and effective life planning and health promotion to adults age 50 and older.

### STRATEGY

1. The division will encourage state residents ages 50 and older to learn about long term care options so they can better meet financial, health and housing needs as they age. The initiative will center on the targeted distribution of its newly developed booklet "A Guide to Community-Based Long Term Care in New Jersey". The guide includes 10 pullout sections detailing programs that provide medical, housing, financial, legal and social service assistance. It also includes consumer checklists and helpful resources for those seeking help for themselves, a family member or friend.
2. Broaden the message of older adult health promotion and disease prevention to engage adults 50 and older, especially those in active adult communities.

### PERFORMANCE MEASURES

1. Outcome data from the pilot implementation of the HealthEASE program in active adult communities. Expansion of the program to other active adult communities.
2. Establishment of new partnerships to expand the Live Long, Live Well Walking Program and the national *You Can!* campaign.
3. Activities delivered in September 2005 as part of the national *You Can!* campaign.

## PRIORITY 3: Support Families in their efforts to care for loved ones at home and in the community.

### TRENDS AND CONDITIONS

There are approximately 800,000[20] informal caregivers in New Jersey, providing 891,200,000 caregiving hours per year and saving New Jersey taxpayers approximately $5.9 billion in service dollars annually.

Additionally, the elderly population (especially the 85+ cohort) is expected to increase by 54% between 1990 and 2010. With the existing shortage of home care workers, caregivers represent the backbone of the long-term care system.

New Jersey is responsive to the many unique needs of caregivers. Programs include mechanisms for greater consumer choice, control, and flexibility in order to support and maintain New Jersey's progressive approach to meeting the needs of caregivers and their loved ones.

[20] The State of the State in Family Caregiver Support: A 50 State Study, November 2004.

## NATIONAL FAMILY CAREGIVER SUPPORT PROGRAM INNOVATION GRANT: NEW JERSEY EASE FOR CAREGIVERS

With funding from a *National Family Caregiver Support Program Innovation Grant*, DACS developed the following products:

**Caregiver Best Practices in New Jersey:** a guide to innovative caregiver programs and services developed by New Jersey agencies for New Jersey residents.

**A Pocket Guide to Caregiver Resources in New Jersey:** a brochure designed to help caregivers identify their needs and gain easy access to existing resources within their communities.

**Understanding Caregivers Across Cultures:** a training curriculum for providers. The goal of the training is to enhance sensitivity to and understanding of caregiving challenges across multiple cultures and help to identify caregivers "at risk" so that they may be referred to appropriate services and resources within the community.

**Culturally Sensitive Approaches to Outreach: A Guide for the Aging Services Network:** a brochure offered to provider agencies as a helpful adjunct to it's organization's practices and strategies for outreach to multicultural clients in the communities they serve.

**The Caregiver NJ Website (www.caregivernj.nj.gov):** an on-line guide to available resources for adults and their families living in New Jersey.

**New Jersey Ethnic Multimedia Contact List:** a listing of radio, TV, and print medium targeted to multicultural audiences across the state. The listing is made available to anyone wishing to use media to improve communication about programs and services available in the community. The list is updated by input from people in the community.

**Caregiver Telephone Screening Tool:** a tool intended to screen family caregivers for being "at risk" and referring them to appropriate services and resources or for a more in depth assessment of caregiver needs by a professional care manager.

**Caregiver Intervention Plan:** a form for use by providers to record assistance and services provided to family caregivers. The form can be referred to later determine if further intervention or assistance is needed over time.

## EXECUTIVE ORDER NO. 100

In 2004, Executive Order No. 100 was issued by then Governor James E. McGreevey and among other previously mentioned directions, it established the *New Jersey Caring for Caregivers Initiative* (CGI). This initiative includes two elements designed to enhance and prolong the ability

of unpaid adult caregivers to continue to provide care to adults with disabilities 18 years of age: either the caregiver or the care recipient must be aged 60+.

1. AAAs are implementing the following three CGI components statewide during CY 05 to fill gaps in existing caregiver services:
   - Professional In-Home Education and Support
   - Caregiver Mental Health Counseling
   - Trained Volunteer Assistance

2. The *Caregiver Direction Respite Pilot Program* has been operational in four counties during CY 05 (Atlantic, Warren, Camden, and Ocean). This pilot program is testing a new way of offering support to caregivers by reimbursing them up to $250 per month ($3,000 per year) to help purchase services.

## ONGOING SERVICES TO ASSIST FAMILIES

DACS, through its Office of Community Programs, supports a variety of programs that offer HCBS.

HCBS refers to assistance with daily activities that generally help people with disabilities remain in their homes. Services such as personal care, chore assistance, transportation, home delivered meals, or adult day services all constitute HCBS. People of all ages with disabilities who use these services live in a variety of settings: their own homes, assisted living facilities, adult family care homes, or subsidized housing.

HCBS programs administered by DACS include Medicaid Waiver programs, **(a)** the *Community Care Program for the Elderly and Disabled* , which served 4,988 recipients during calendar year 2004, **(b)** the *Assisted Living Program,* through which a total of 3,582 unduplicated individuals were served by October 2004, **(c)** *Adult Family Care* (AFC), which served 55 unduplicated individuals in calendar year 2004, and (d) the *Caregiver Assistance Program* (CAP), which has served 3,501 unduplicated individuals since 2000 (see Chapter 4 for program details).

HCBS are also available through state funded programs. These programs include **(a)** *Jersey Assistance for Community Caregivers*, which has served 3,694 unduplicated individuals since 2000, **(b)** *Statewide Respite Care Program*, serving approximately 3,900 families each year, **(c)** *Alzheimer's Adult Day Health Services*, which served 721 clients in State Fiscal Year 2004, and **(d)** the *Congregate Housing Services Program* which provided services to 2,658 participants in calendar year 2004 (see Exhibit 8).

## OLDER AMERICANS ACT SERVICES

With Title III E funds, New Jersey's AAAs have developed a wide variety of programs to meet the needs of caregivers, including information, assistance, counseling, support groups, training, and respite care. In addition, a variety of supplemental services are provided to *Caregivers of Seniors* and *Grandparents Raising Grandchildren* (see Exhibit 9).

NJ DEPARTMENT OF HEALTH AND SENIOR SERVICES ◆ DIVISION OF AGING & COMMUNITY SERVICES

# Division of Aging and Community Services
# Comparison of Case-Managed Programs and Services

**EXHIBIT 8**

| WAIVER | CCPED | ENHANCED COMMUNITY OPTIONS | | | NON-WAIVER |
|---|---|---|---|---|---|
| PROGRAM | CCPED | AL | AFC | CAP | JACC |
| Medicaid State plan Services | 0. Medical Day Care<br>1. Transportation<br>2. Home Health*<br>3. Prescribed Drugs | 4. All except Nursing Facility, Personal Care Assistance, Adult Day Health, and Hospice | 5. All except Nursing Facility, Personal Care Assistance, and Hospice | 6. All except Nursing Facility, Personal Care Assistance, and Hospice | 7. None |
| Waiver Services | 8. Care Management<br>9. Homemaker<br>10. Respite<br>11. Social ADC | 12. Care Management<br>13. Assisted Living<br>14. Social Adult Day Care (ALP only) | 15. Care Management<br>16. Adult Family Care<br>17. Environmental Accessibility Adaptation<br>18. Social Adult Day Care<br>19. Transportation<br>20. Respite | 21. Care Management<br>22. Homemaker<br>23. Respite<br>24. Env Acc Adapt<br>25. SME & Supplies<br>26. Chore<br>27. PERS<br>28. Attendant Care<br>29. Home delivered meal service<br>30. Caregiver/Recipient training<br>31. Social Adult Day Care<br>32. Home-Based Supportive Care<br>33. Transportation | 34. Care Management<br>35. Homemaker<br>36. Respite<br>37. Env Acc Adapt<br>38. SME & Supplies<br>39. Chore<br>40. PERS<br>41. Attendant Care<br>42. Home delivered meal service<br>43. Caregiver/Recipient training<br>44. Social Adult Day Care<br>45. Home Based Supportive Care<br>46. Adult Day Health (Med. Day Care)<br>47. Transportation |
| Eligibility – Financial | 48. Medicaid Only (Institutional)<br>Monthly income ≤ $1,737<br>Resources ≤ $2,000 | 49. SSI<br>Monthly income $610.25<br>Resources ≤ $2,000<br>50. Medicaid Only (Institutional)<br>Monthly Income ≤ $1,737<br>Resources ≤ $2,000<br>51. NJ Care<br>Monthly Income < 100% FPL<br>Resources ≤ $4,000 | 52. SSI<br>Monthly income $610.25<br>Resources ≤ $2,000<br>53. Medicaid Only (Institutional)<br>Monthly Income ≤ $1,737<br>Resources ≤ $2,000<br>54. NJ Care<br>Monthly Income < 100% FPL<br>Resources ≤ $4,000 | 55. SSI<br>Monthly income $610.25<br>Resources ≤ $2,000<br>56. Medicaid Only (Institutional)<br>Monthly Income ≤ $1,737<br>Resources ≤ $2,000<br>57. NJ Care<br>Monthly Income < 100% FPL<br>Resources ≤ $4,000 | 58. Non-Medicaid eligible<br>Assets below:<br>$40,000 Individual or<br>$60,000 Couple<br>Countable income*** < 365% FPL |
| Other Eligibility | 3rd party insurance | | | | |
| Clinical Eligibility | NF Level of Care | NF Level of Care | NF Level of Care | NF Level of Care | NF Level of Care |
| Age Requirements | 65 or older; under 65 with disability | 65 or older; 21-64 with disability | 65 or older; 21-64 with disability | 65 or older; 21-64 with disability | 60 or older |
| Funding | State/Federal Match | State/Federal Match | State/Federal Match | State/Federal Match | State Funds |
| Consumer –Directed Approach | NO | NO | NO | YES | YES |
| Billing Agent | NO | NO | NO | YES | YES |
| Governing Code | NJAC 10:60 | | | | |
| Licensed | NO | YES NJAC 8:36 | YES NJAC 8:43B | NO | NO |
| Cost Share | NO | YES** | YES | NO | YES |
| Cost Cap | 70%=$1,989/month; 100%=$2,841/month | | | $1100/month, $13,200year | $600/month, $7200 year |

*Fee for service reimbursed at established rates **No cost share in ALP ***Gross income less allowable medical deductions

NJ DEPARTMENT OF HEALTH AND SENIOR SERVICES ◆ DIVISION OF AGING & COMMUNITY SERVICES

# Title III E Populations Served for Calendar Year 2004

**EXHIBIT 9**

| Federal III E Category/ NJ Taxonomy and Unit of Service | Total Units | Total Clients | African American Clients | Hispanic Clients | Asian Clients | American Indian Clients | Total Minority Clients | Non-Minority Clients | Total Poverty Clients | Minority Poverty Clients | Non-Minority Poverty Clients |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Information to Caregivers:** | | | | | | | | | | | |
| Information and Assistance - contact | 28,044 | 14,348 | 826 | 503 | 302 | 4 | 1,635 | 12,713 | 1,269 | 589 | 680 |
| Newsletter - each edition | 4 | 21,900 | 995 | 995 | 995 | - | 2,985 | 18,915 | 501 | 173 | 328 |
| *Subtotal Caregivers of Seniors* | *28,048* | *36,248* | *1,821* | *1,498* | *1,297* | *4* | *4,620* | *31,628* | *1,770* | *762* | *1,008* |
| *Subtotal Grandparents* | - | - | - | - | - | - | - | - | - | - | - |
| **Total** | **28,048** | **36,248** | **1,821** | **1,498** | **1,297** | **4** | **4,620** | **31,628** | **1,770** | **762** | **1,008** |
| **Assistance to Caregivers:** | | | | | | | | | | | |
| Benefits Screening - 1/2 hour | 925 | 322 | 26 | 4 | 2 | - | 32 | 290 | 32 | 13 | 19 |
| Extended Assessment - 1/2 hour | 747 | 233 | 23 | 2 | 2 | - | 27 | 206 | 35 | 12 | 23 |
| Outreach - contact | 5,146 | 3,485 | 848 | 568 | 33 | 4 | 1,453 | 2,032 | 571 | 406 | 165 |
| Care Management - 1/2 hour | 47,613 | 2,527 | 307 | 142 | 15 | 1 | 465 | 2,062 | 666 | 228 | 438 |
| Legal Assistance - hour | 489 | 66 | 31 | 9 | - | - | 40 | 26 | 43 | 39 | 4 |
| *Subtotal Caregivers of Seniors* | *54,920* | *6,633* | *1,235* | *725* | *52* | *5* | *2,017* | *4,616* | *1,347* | *698* | *649* |
| GP, Outreach - outreach | 40 | 25 | 16 | 9 | - | - | 25 | - | 25 | 25 | - |
| GP, Care Management - 1/2 hour | 2,118 | 61 | 24 | 1 | - | - | 25 | 36 | 21 | 21 | - |
| GP, Legal Assistance - hour | 7 | 35 | 32 | 3 | - | - | 35 | - | 35 | 35 | - |
| *Subtotal Grandparents* | *2,165* | *121* | *72* | *13* | *-* | *-* | *85* | *36* | *81* | *81* | *-* |
| **Total** | **57,085** | **6,754** | **1,307** | **738** | **52** | **5** | **2,102** | **4,652** | **1,428** | **779** | **649** |
| **Counseling, Support Groups, Training:** | | | | | | | | | | | |
| Support Group - group meeting | 596 | 725 | 48 | 9 | 9 | - | 66 | 659 | 39 | 3 | 36 |
| Mental Health - hour | 5,218 | 948 | 183 | 71 | 28 | 1 | 283 | 665 | 246 | 125 | 121 |
| Counseling - hour | 358 | 520 | 1 | 5 | 2 | - | 8 | 512 | 9 | 3 | 6 |
| Education - hour | 9,621 | 2,523 | 345 | 214 | 26 | 2 | 587 | 1,936 | 309 | 126 | 183 |
| *Subtotal Caregivers of Seniors* | *15,793* | *4,716* | *577* | *299* | *65* | *3* | *944* | *3,772* | *603* | *257* | *346* |
| GP, Support Group - group meeting | 27 | 72 | 45 | 3 | - | - | 48 | 24 | 42 | 40 | 2 |
| GP, Mental Health - hour | 357 | 30 | 21 | 2 | 2 | - | 25 | 5 | 9 | 7 | 2 |
| **Subtotal Grandparents** | *384* | *102* | *66* | *5* | *2* | - | *73* | *29* | *51* | *47* | *4* |
| **Total** | **16,177** | **4,818** | **643** | **304** | **67** | **3** | **1,017** | **3,801** | **654** | **304** | **350** |

NJ DEPARTMENT OF HEALTH AND SENIOR SERVICES ◆ DIVISION OF AGING & COMMUNITY SERVICES

# Title III E Populations Served for Calendar Year 2004

**EXHIBIT 9**

| Federal III E Category/ NJ Taxonomy and Unit of Service | Total Units | Total Clients | African American Clients | Hispanic Clients | Asian Clients | American Indian Clients | Total Minority Clients | Non-Minority Clients | Total Poverty Clients | Minority Poverty Clients | Non-Minority Poverty Clients |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Respite Care:** | | | | | | | | | | | |
| Certified Home Health Aid - hour | 21,117 | 429 | 148 | 41 | 1 | - | 190 | 239 | 281 | 145 | 136 |
| Visiting Nurse - visit | 50 | 23 | 9 | 1 | - | - | 10 | 13 | 4 | 4 | - |
| Respite - hour | 73,958 | 804 | 101 | 25 | 4 | 2 | 132 | 672 | 259 | 58 | 201 |
| Adult Day Social - hour | 54,379 | 347 | 42 | 18 | 7 | 1 | 68 | 279 | 88 | 29 | 59 |
| Adult Day Medical - hour | 49,488 | 178 | 52 | 4 | 1 | - | 57 | 121 | 117 | 43 | 74 |
| Personal Care - hour | 1,781 | 93 | 2 | - | 6 | - | 8 | 85 | 74 | 6 | 68 |
| *Subtotal Caregivers of Seniors* | *200,773* | *1,874* | *354* | *89* | *19* | *3* | *465* | *1,409* | *823* | *285* | *538* |
| GP, Respite - hour | 77 | 10 | 10 | - | - | - | 10 | - | 10 | 10 | - |
| *Subtotal Grandparents* | *77* | *10* | *10* | - | - | - | *10* | - | *10* | *10* | - |
| **Total** | **200,850** | **1,884** | **364** | **89** | **19** | **3** | **475** | **1,409** | **833** | **295** | **538** |
| **Supplemental Services:** | | | | | | | | | | | |
| Assisted Transportation - contact | 2,509 | 135 | 5 | 18 | 6 | - | 29 | 106 | 30 | 23 | 7 |
| Friendly Visiting - visit | 6,129 | 200 | 4 | 6 | 2 | 1 | 13 | 187 | 29 | 9 | 20 |
| Telephone Reassurance - call | 3,169 | 66 | 7 | 10 | - | - | 17 | 49 | 6 | 3 | 3 |
| Residential Maintenance - hour | 1,715 | 146 | 15 | 4 | 3 | - | 22 | 124 | 45 | 27 | 18 |
| Housekeeping - hour | 1,944 | 57 | 8 | 15 | - | - | 23 | 34 | 39 | 18 | 21 |
| Emergency - contact | 179 | 41 | 7 | 2 | - | - | 9 | 32 | 13 | 2 | 11 |
| Physical Health - contact | 1,649 | 394 | 29 | 13 | 1 | - | 43 | 351 | 65 | 8 | 57 |
| Physical Fitness - activity | 341 | 16 | - | - | - | - | - | 16 | - | - | - |
| Social Recreation - activity | 17 | 12 | - | - | - | - | - | 12 | - | - | - |
| Home Delivered Meals - meal | 26,285 | 165 | 11 | 9 | - | - | 20 | 145 | 74 | 20 | 54 |
| *Subtotal Caregivers of Seniors* | *43,937* | *1,232* | *86* | *77* | *12* | *1* | *176* | *1,056* | *301* | *110* | *191* |
| GP, Social Recreation | 578 | 72 | 71 | - | - | - | 71 | 1 | 60 | 59 | 1 |
| *Subtotal Grandparents* | *578* | *72* | *71* | - | - | - | *71* | *1* | *60* | *59* | *1* |
| **Total** | **44,515** | **1,304** | **157** | **77** | **12** | **1** | **247** | **1,057** | **361** | **169** | **192** |
| **Grand Total Title III E Services** | **346,675** | **51,008** | **4,292** | **2,706** | **1,447** | **16** | **8,461** | **42,547** | **5,046** | **2,309** | **2,737** |
| *Subtotal Caregivers of Seniors* | 343,471 | 50,703 | 4,073 | 2,688 | 1,445 | 16 | 8,222 | 42,481 | 4,844 | 2,112 | 2,732 |
| *Subtotal Grandparents* | 3,204 | 305 | 219 | 18 | 2 | - | 239 | 66 | 202 | 197 | 5 |

**GOAL 1:** **To improve caregiver skills in using the home environment for dementia care. Create a model for integrating home modifications and assistive technologies into ADRC processes.**

## STRATEGY

1. Working with New Jersey's two ADRC's, staff will be trained to provide 60 families (at least 20 from diverse communities) with environmental assessments, education, intervention planning and implementation to improve family dementia care. The contractor will also work with a selected Alzheimer's Adult Day Services Program and a community organization serving a diverse population to assess and recommend physical plant changes to better serve individuals with dementia.

## PERFORMANCE MEASURES

Products will include a final report with a proposal for a full Alzheimer's Disease Demonstration Grants (ADDGS) program, a "train the trainer" curriculum and a DVD/video and a project evaluation.

**GOAL 2:** **Develop a coordinated care management and service delivery model to assist older caregivers providing assistance to adults with developmental, physical, and/or mental disabilities.**

## STRATEGY

1. DACS will implement a county-based, family-centered pilot program serving the aging and disability community. The purpose of this pilot is to establish an interagency care management model encompassing an interdisciplinary team and family-centered approach to identify consumer needs, obtain supports and secure needs-based delivery of services.
2. Participating agencies include DACS, the New Jersey Division of Developmental Disabilities, the New Jersey Division of Disability Services, the New Jersey Division of Mental Health Services, participating AAAs, and the University of Medicine and Dentistry of New Jersey School of Medicine (UMDNJ).
3. Participating families will be able to benefit from services available through most or all of the above agencies. Eligibility includes older caregivers 60+ and their children with significant disabilities age 35+. Only families already known to one of the participating agencies will be eligible. The partnership's goal is to serve 20 families through this initiative.

## ALZHEIMER'S DISEASE DEMONSTRATION GRANTS (ADDGS)

DACS has applied for AoA's *Alzheimer's Disease Demonstration Grants to States* to contract with an architectural research center, specializing in environments for persons with dementia, to conduct a one-year capacity building project utilizing environmental interventions and assistive technologies as tools for dementia care.

## OUTCOMES

Expected outcomes include **(a)** improved caregiver skills in using the home environment for dementia care; **(b)** a model for integrating home modifications and assistive technologies into ADRC processes; and **(c)** recommendations for improving provider physical plants to better serve individuals with dementia.

## PERFORMANCE MEASURES

DACS will implement the actions listed above in order to help caregivers who care for adults with developmental, physical, and/or mental disabilities.

### GOAL 3: Implement a caregiver-directed service component statewide through the state-funded Statewide Respite Care Program.

## STRATEGY

1. Following the calendar year 2005 Caregiver-Directed Respite Pilot Program, roll out this option statewide in calendar year 2006 as a component of the Statewide Respite Care Program service package.
2. Will begin Caregiver-Directed Respite Program training for all of the program's sponsor agencies in June 2005, so sponsor agencies are ready to implement in January 2006.

## PERFORMANCE MEASURES

DACS will implement the Respite Care Program statewide beginning in 2006.

## PRIORITY 4: Ensure the rights of older people and prevent their abuse, neglect and exploitation.

## TRENDS AND CONDITIONS

As the American population continues to age and families continue to be geographically dispersed, more and more older Americans are spending their later years in long-term care facilities. It is estimated that by the year 2020, more than 13 million Americans will require nursing home care. Many of these individuals will be suffering from dementias, such as Alzheimer's, and other conditions that make them particularly vulnerable to abuse, neglect, and exploitation.

In 2000 there were 1.4 million persons age 60 or older in New Jersey. By 2025 it is estimated to be 2.5 million. Of men and women 85 years old or older, 22% and 28%, respectively, have disabilities. Given that longevity is increasing, more elderly persons will be disabled in coming years, thus requiring increased care, including guardianships.

Finally, that portion of the population in the community that is considered frail, elderly, and at-risk will likewise continue to grow. With that growth comes the susceptibility to physical, psychological, or sexual abuse, self-neglect or caregiver neglect, and financial exploitation. It will remain a challenge for New Jersey and its partners in the aging and disability services network to keep these individuals in the community with as much independence and safety as possible.

**GOAL 1:** **Ensure, through the Office of the Ombudsman for the Institutionalized Elderly, that nursing home staff and volunteer advocates are trained to spot, prevent or stop and report incidents of resident mistreatment and promote a culture of caring in institutional settings.**

## OBJECTIVES

1. Recruit and place trained and caring volunteer advocates in every New Jersey nursing home and assisted living residence (currently numbering approximately 560).
2. Sensitize nursing home and assisted living administrators and staff to the special needs and ethical dilemmas confronting their residents and to provide them with the resources to address same, in the form of regional ethics advisory committees.
3. Develop and promote a culture of caring among nursing home administrators and staffs.

## STRATEGY

1. Solicit grants to fund a statewide media campaign to **(a)** increase awareness of the Ombudsman program, thereby improving the availability of the advocacy and protections of the program, and **(b)** to reach a greater audience of potential volunteer advocates.
2. Continue the Office of the Ombudsman's program of training and support of the statewide network of Regional Long-Term Care Ethics Committees.
3. Promote "buy-in" by nursing home and assisted living administrators and staff of a culture of caring through continued education and support in the areas of palliative care and leadership, team building, and dispute resolution.
4. Partner with non-profit organizations, educational institutions, and other governmental agencies, as necessary, to accomplish these goals.

## PERFORMANCE MEASURES

The Office of the Ombudsman for the Institutionalized Elderly is developing a resident satisfaction survey, to be administered on a regular basis by volunteer advocates.

**GOAL 2:** **Through the Office of the Public Guardian for Elderly Adults, educate the public and work with professionals to ensure that guardianship and alternatives to guardianship are understood and properly utilized.**

## OBJECTIVES

1. Educate family members and friends about the need for advance planning, durable powers of attorney, and health care proxies.
2. Educate the public about the guardianship process and the fiduciary duty of being a guardian.
3. Continue to strengthen the Office of the Public Guardian for Elderly Adults to assure that if family or friends are not willing or appropriate to serve as guardian that the Public Guardian will be available for them.
4. Collaborate with New Jersey State Bar Association, unaffiliated attorneys, agencies, physicians, medical and long term care institutions, and others to assure that guardianship services are available when necessary.

## STRATEGY

1. Increase funding for the Office of the Public Guardian through fees, commissions, and other sources of revenue in order to be able to serve the incapacitated elderly as the number and complexity of cases increase.
2. Develop with the New Jersey State Bar Association and other organizations an education campaign for the general public about advance directives or health care proxies.
3. Provide information and promote understanding about guardianships through continuing education with the medical and nursing professions, agencies, and others.
4. Seek grant funds to assist in supporting the educational processes.
5. Produce a short video about the guardianship process that can be given to families and interested parties.
6. Continue to work with the Office of the Ombudsman for the Institutionalized Elderly Volunteer program.
7. Collaborate with non-profit agencies, the Office of the Ombudsman for the Institutionalized Elderly, and government agencies to accomplish the strategies listed above.

## PERFORMANCE MEASURES

The Public Guardian is developing a video, has started working with the Office of the Ombudsman for Institutionalized Elderly Volunteer program, and will continue to work toward achieving the strategies during the coming year.

**GOAL 3:** **Through Adult Protective Services, support county provider agencies and educate and work with partner agencies to ensure that vulnerable adults are identified and that services are provided to them in order to ensure their safety in the community.**

## OBJECTIVES

1. Continue to support each county Adult Protective Services provider agency with funding, technical support, and training as the program prepares for the rapid growth of the aging population.
2. Educate the public and other professionals with regard to the responsibilities, jurisdiction, and limitations of Adult Protective Services.
3. Work collaboratively with other agencies to insure the safety of clients receiving services from both Adult Protective Services and another service provider. The focus of this collaboration is with the Division of Mental Health Services (DMH) and the Division of Developmental Disabilities (DDD).

## STRATEGY

1. Increase funding for Adult Protective Services as the number of investigations and case complexity grows (see Exhibit 10).
2. Intensify the public awareness campaign through brochures and workshops for professionals and the general public.
3. Modify the curriculum of the Adult Protective Services basic training, advanced worker training and Supervisor training to address emerging issues.
4. Complete Memoranda of Understanding with both the Division of Mental Health Services and the Division of Developmentally Disabled that will facilitate service delivery to common clients.

## PERFORMANCE MEASURES

APS developed 28 performance standards in 2000. Annually each of the 21 Adult Protective Services provider agencies is monitored and case files are measured against those standards. Particular attention is paid to response times, flexibility of the care plan as circumstances change, interventions used, and respect for the client's rights.

**EXHIBIT 10**

## ADULT PROTECTIVE SERVICES (APS)

| COUNTY | 2003 APS | | 2004 APS | | 2004 VS. 2003 | |
|---|---|---|---|---|---|---|
| | Investigated | Validated | Investigated | Validated | % Investigated | % Validated |
| Atlantic | 436 | 385 | 441 | 407 | 1% | 6% |
| Bergen | 440 | 189 | 452 | 263 | 3% | 39% |
| Burlington | 219 | 165 | 251 | 185 | 15% | 12% |
| Camden | 230 | 74 | 239 | 77 | 4% | 4% |
| Cape May | 10 | 5 | 33 | 7 | 230% | 40% |
| Cumberland | 86 | 16 | 83 | 22 | -3% | 38% |
| Essex | 266 | 127 | 258 | 188 | -3% | 48% |
| Gloucester | 93 | 37 | 78 | 33 | -16% | -11% |
| Hudson | 541 | 462 | 602 | 474 | 11% | 3% |
| Hunterdon | 97 | 74 | 122 | 85 | 26% | 15% |
| Mercer | 175 | 97 | 200 | 78 | 14% | -20% |
| Middlesex | 269 | 134 | 489 | 151 | 82% | 13% |
| Monmouth | 249 | 79 | 226 | 68 | -9% | -14% |
| Morris | 75 | 26 | 74 | 34 | -1% | 31% |
| Ocean | 505 | 394 | 582 | 437 | 15% | 11% |
| Passaic | 172 | 104 | 203 | 137 | 18% | 32% |
| Salem | 71 | 21 | 68 | 26 | -4% | 24% |
| Somerset | 127 | 44 | 127 | 42 | 0% | -5% |
| Sussex | 75 | 37 | 46 | 15 | -39% | -59% |
| Union | 118 | 52 | 134 | 63 | 14% | 21% |
| Warren | 67 | 35 | 79 | 32 | 18% | -9% |
| TOTAL | 4321 | 2557 | 4787 | 2824 | 11% | 10% |

## PRIORITY 5: Promote effective and responsive management.

### WHAT DACS HAS DONE AND WHAT THIS HAS ACCOMPLISHED

### INTERNALLY

| WHAT WAS DONE | WHAT WAS ACCOMPLISHED |
|---|---|
| Reorganized two divisions with common missions to support seniors in the community into one (the Divisions of Senior Affairs and Consumer Support). | Created Division of Aging and Community Service (DACS).<br>Streamlined administrative practices. |
| Adopted a mission and vision for the new division. | Provided guidance for all activities. |
| Held regular meetings for all staff (250+), and retreats for managers (25+). | Informed and energized staff.<br>Created forum for open dialog on work issues |
| Held inter-unit meetings to support division cohesion. | Opened lines of communication throughout DACS<br>Identified efficiencies in program administration |

### EXTERNALLY

| WHAT WAS DONE | WHAT WAS ACCOMPLISHED |
|---|---|
| Reformatted and restructured the AAA Executive Director meetings. | Communications were improved with Executive Directors. Before each meeting an agenda is presented. Meetings include PowerPoint reports from Assistant Commissioner, AAA Administration and AAA Grants Management, among other speakers. Minutes documenting the discussion are written after each meeting for approval at following one. |
| Conducted roundtable discussions with NJ4A, the Area Agencies on Aging State Board. | Direct input from AAA leadership gained: a platform for dialogue on national issues, county concerns and disparities. Provided an arena to focus on agenda items for the Executive Director meetings. Results included a finance committee and regularly scheduled visits to each AAA office: at least twice per year. |
| Joined with DACS's partners in the Dept. of Human Services to work on common issues and initiatives including interagency planning, Medicare Part D implementation, and the ADRC grant, and the Developmental Disabilities Council. | Ensured that key partners were involved in all stages of project development and implementation.<br>Improved the ability to implement program changes in shorter period of time. |
| Worked with Governor's Office on drafting of Executive Orders No. 100 and No. 31. | Governor issued Executive Orders No. 100 and No. 31 taking the DHSS recommendations. |
| Pursued grants to improve access to information and services. | NJEASE for Caregiver grant; ADRC; PACE Technical Assistance grant. |

# WHAT DACS PLANS TO DO AND HOPES TO ACCOMPLISH

## INTERNALLY

| WHAT DACS PLANS TO DO | WHAT DACS HOPES TO ACCOMPLISH |
|---|---|
| Continue to hold regular meetings for all staff and retreats for managers. | Inform and energize staff<br>Maintain open dialog on work issues |
| Continue to hold inter-unit meetings to support division cohesion. | Open lines of communication throughout division.<br>Identify efficiencies in program administration |

## EXTERNALLY

| WHAT DACS PLANS TO DO | WHAT DACS HOPES TO ACCOMPLISH |
|---|---|
| Work with Governor's office to implement global budgeting. | Flexibility will ensure more seniors and persons with disabilities in need of long-term care services can receive them in the community. |
| Through advocacy, planning, coordination, inter-agency linkages, information sharing, brokering, monitoring, and evaluation, lead the way in developing and enhancing a comprehensive and coordinated system of community care. | Implement ADRC pilot projects in two counties and look to expand further – a streamlined, visible, and trusted system for aged and disabled individuals. |
| Establish PACE models in NJ. | Build state capacity and partnering<br>Develop rates and requirements |
| Seek out and establish new partnerships with public and private entities to address service needs. | DD Mental Health (DD & E. Bogg Center)<br>Private industry<br>NJ Business and Industry Association<br>Integrated Health Systems<br>Health Care Associations |
| Seek funding for innovative programs that benefit seniors, caregivers, and persons with physical disabilities. | Alzheimer's disease grant<br>Other initiatives under Community Education & Wellness. |
| Improve, monitor, and evaluate programs to ensure quality. | CMS Model for Home and Community-Based Waivers<br>ADRC<br>AAA Performance Standards<br>Care Management Standards<br>Alliance of Information and Referral Systems (AIRS) standards |
| Provide updated and ongoing technical assistance to the AAAs, so they may continue as the lead agencies in developing coordinated systems of community based services. | Training and support leading to increased fiscal accountability, data gathering and monitoring capabilities. |

## GOAL 1: Continue to implement DACS's annual AAA Assessment Procedure.

### OBJECTIVES

1. Ensure that AAAs are accountable with regard to the performance of services they provide under Title III of the OAA.
2. Ensure that DACS is responsive to AAA evaluation of its leadership and its service delivery capacity.

### STRATEGY

1. Review and evaluate the Self-Assessment Tool completed by each AAA.
2. Review and evaluate the required forms completed by each AAA pertaining to compliance issues, important events, AAA initiatives, best practices, and program highlights during the previous year.
3. Review the AAA evaluation of DACS.
4. Review AAAs' in-house data.
5. Conduct the assessment site visit.
6. Complete post-assessment activities.

### PERFORMANCE MEASURES

The Office of Area Agencies on Aging Administration has focused its efforts on refining the performance measures for the assessment of services provided under Title III of the OAA as well as provider operations and execution. In addition, the collection of timely, accurate, and comparable data is of growing importance to DACS. Through annual performance reports, the AAA Administration office provides detailed information on the local AAAs and their progress in meeting objectives. DACS will soon be utilizing this accountability system not only to document results but to justify funding under the global budget concept.

## GOAL 2: Provide new and ongoing technical assistance to the AAAs to support their role as senior planning and service leaders at the local level.

### OBJECTIVES

DACS's objective is to support the 21 AAAs in New Jersey so that they can successfully accomplish their respective goals.

## STRATEGY

1. Each year, DACS offers two training sessions to AAA staff including a four-day information and assistance training and an eight-day core care management training. In addition, a series of one-day training programs are offered throughout the year to AAA staff and other members of the aging network. The topics for these training sessions are determined from surveys that are sent to the AAA directors, care coordinators, and care managers. DACS has also developed and will be offering new training opportunities on cultural diversity, customer service excellence, and consumer direction.

## PERFORMANCE MEASURES

DACS will provide technical assistance to the AAAs to support their role as senior planning and service leaders at the local level, leading to increased fiscal accountability, data gathering and monitoring capabilities.

## AREA AGENCY ON AGING (AAA) ASSESSMENT PROCESS

Each year DACS conducts an assessment of the AAAs to evaluate their performance and operations during the prior year. All AAAs are required to return a completed Self-Assessment Tool and the forms entitled **(a)** Compliance Issues and Important Events, **(b)** AAA Initiatives, Best Practices and Program Highlights During 2004, and **(c)** AAA Evaluation of the Division of Aging and Community Services. An electronic version has also been sent to AAA Directors. This Self-Assessment Tool was developed to reflect feedback from AAA directors and input from State administration staff.

Annually, DACS conducts a desk review of the required documentation for all 21 counties and an on-site assessment visit to seven counties. Each AAA will be subject to an on-site assessment every third year, unless circumstances warrant a timelier visit. Technical assistance and monitoring visits will continue annually and on an as-needed basis. See a detailed outline of the AAA Annual Assessment Procedures in Attachment G.

## OPEN COMPETITION FOR OLDER AMERICANS ACT FUNDS STATE AND AREA AGENCY ON AGING (AAA) CONTRACTING POLICY AND PROCEDURES

DACS, as required under the OAA and in conformance with state law, provides requirements as a component of the Area Plan Contract for a free, open and competitive process for awarding funds. The competitive contracting Request for Proposal (RFP) process and methodology for awarding contracts are administered by the AAA Executive Director in concert with the county designated purchasing agent pursuant to Public Law 1999, Chapter 440.

Other services administered directly by the AAA require that the agency submit to the State a request for a direct service waiver in accordance with division policy. In order to substantiate the need for a waiver, the AAA must provide assurances and supporting documentation to DACS demonstrating the following:

- Provide evidence that the cost of the activity is competitive with other not-for-profit organizations that provide similar services;
- Document their capacity to provide program, fiscal and administrative oversight and;
- Substantiate that the resources and services needed, would best be provided by them.

Counties must use the RFP and/or waiver contract process to ensure service delivery. In addition, direct quality assurance and performance review of the subcontractor is the responsibility of the AAA. However, DACS will review the performance review results and methodology, and will ensure follow-up on any compliance issues.

## COMPETITION VIS-À-VIS COST AND QUALITY OF CARE

DACS has begun to address the impact of competition and the provision of services under the OAA and it's affect on cost and quality of service by implementing team monitoring visits in select nutrition programs.

## OFFICE OF COMMUNITY PROGRAMS MONITORING

In 2005, DACS' Office of Community Programs implemented a new approach to monitoring and promoting quality performance of agencies that locally administer the Community Care Program for the Elderly and Disabled, the Assisted Living, and the Caregivers Assistance Program Medicaid Waivers, as well as the state-funded Jersey Assistance for Community Caregivers program.

Based on the CMS Quality Framework, DACS's on-going oversight and monitoring efforts now rely largely on the ability to demonstrate quality assurance through evidentiary-based information.

## GOAL 3: Improve, monitor, and evaluate HCBS Waiver programs to ensure quality.

## OBJECTIVES

DACS objective is to measure the extent to which policies and procedures have been implemented and quality improvement is practiced. The ability to do so directly enhances the effectiveness and responsiveness of DACS.

## STRATEGY

1. Site Visit: The Office of Community Programs monitors care management agencies on an annual basis. Teams of three or four State representatives conduct a two-day on-site visit during which time **(a)** participants are interviewed by mail, phone, and face-to-face consultation, **(b)** care managers are interviewed, and **(c)** participant files are thoroughly examined.

2. Surveys: The care management agency completes and returns a questionnaire to the team prior to the visit so that areas of concern can be discussed on-site.

An array of survey tools are used to discover and quantify findings with regards to program administration in areas such as:

- Process efficiency and timeliness
- Eligibility and level of care determination
- Monitoring plans of care
- Provider qualifications
- Participant health and well-being
- Whether participants are afforded choice and the ability to direct their own care

## PERFORMANCE MEASURES

**Interviews:** Extensive entrance and exit interviews are conducted by the team so all parties are aware of the day's agenda and the team's findings. If deficiencies are found, a plan of correction is warranted within thirty days and follow-up occurs as necessary. This system of on-going oversight and data collection enables the division to discover problems as they occur and work toward timely remediation, thereby ensuring continuous program improvement.

## QUALITY ASSURANCE AND QUALITY IMPROVEMENT PROCESS

The framework for DACS's Quality Initiative (DACSQI) will be based upon the guidelines developed by CMS for HCBS. This initiative will use the formal CMS Quality Framework using the functions of design, discovery, remedy, and system improvement.

**Design:** "*Designing quality assurance and improvement strategies into the HCBS program at the initiation of the program*." The collection of data for performance measures, indicators and proxies will be to first leverage all available administrative data. Three databases that will be used in QI process are:

- Area Plan Contract Reporting System
- State Aging Funded Programs (e.g., Jersey Assistance Community Caregivers, Statewide Respite, Alzheimer's Adult Day Services Program, Congregate Housing Services Program, etc.)
- New Jersey's Medicaid MMIS (Medicaid Waiver Programs)

**Discovery:** "*Engaging in a process of discovery to collect data and direct participant experiences in order to assess the ongoing implementation of the program, identifying both concerns as well as other opportunities for improvement*." Opportunities for quality improvement will flow from three primary disciplines: data analyses, business process improvement analyses and through focus groups and interviews.

**Remedy:** "*Taking actions to remedy specific problems or concerns that arise in the discovery process*." Built into the QI process will be the development and implementation of effective solutions for cross-functional and organizational processes. A workgroup comprised of representatives from the Resource Centers, consumer representatives, partners, and principal stakeholders will be established to assist with QI.

**Systems Improvement:** Once a business process has been developed and approved, the protocols documented and appropriate staff trained, the new processes are implemented and the quality cycle begins again leading to continuous quality improvement. In addition, experiences will be documented and reviewed for lessons learned and to determine techniques for reducing time to implementation.

**Priority Areas for Quality Assessment:** DACS's priority areas for quality assessments include the following:

- Participant access
- Participant-centered service planning and delivery
- Provider capacity and capabilities
- Participant safeguards
- Participant rights and responsibilities
- Participant outcomes and satisfaction
- System performance

The State will incorporate best practices as a cornerstone for building its assessment tools. Benchmarking and cost targets are some of the tools that will be used to assess performance.

## GOAL 4: Promote DACS's Quality Assurance and Quality Improvement Process throughout all programs and services.

DACS intends to monitor its AAA service providers' mission-critical functions and improve service delivery structure. It will do so by implementing integrated and flexible Information Technology (IT) solutions in order to deliver consistent high quality level services, access AAA network performance information, review and optimize resources, and manage change and improvements.

## OBJECTIVES

DACS' goals, objectives, and activities are designed specifically to ensure that:

1. The model will increase visibility
2. It will be viewed as trustworthy
3. It will make it easier to access information and services
4. It will be more responsive to the needs of consumers
5. The service delivery system will become more efficient and effective

## STRATEGY

1. Quality improvement will include the following activities:

    a. Establish management responsibilities
    b. Define processes and goals and identify consumer/stakeholder requirements
    c. Define and establish measures
    d. Assess conformance to consumer/stakeholder requirements
    e. Investigate process to identify improvement opportunities
    f. Rank improvement opportunities and set objectives
    g. Improve process quality

## PERFORMANCE MEASURES

Performance goals are aligned with desired consumer and stakeholder outcomes, which will be measured through consumer/stakeholder surveys, interviews, and focus group sessions. The indicators are in-process measures that tell DACS how it's doing as it strives to reach its desired outcomes.

## GOAL 5: Seek funding for innovative programs that benefit seniors, caregivers, and people with physical disabilities

### ALZHEIMER'S DISEASE DEMONSTRATION GRANTS (ADDGS)

DACS has applied for AoA's *Alzheimer's Disease Demonstration Grants to States* to contract with an architectural research center, specializing in environments for persons with dementia, to conduct a one-year capacity building project utilizing environmental interventions and assistive technologies as tools for dementia care.

### PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

PACE is a Medicare and Medicaid comprehensive managed care program, covering health and social services for frail individuals age 55 and older who wish to remain in the community.

### OBJECTIVES

New Jersey was selected by the *National Pace Association* to receive technical assistance to analyze potential markets for developing PACE.

### STRATEGY

1. In addition to funding feasibility studies to determine the best locations for PACE, this award provided education for State staff and outreach to communities and potential providers. Funding for these studies came from the CMS.

### PERFORMANCE MEASURES

DACS will develop Medicaid rates, solicitation strategies, licensing requirements, and program policies to establish PACE in New Jersey.

## GOAL 6: Reform long-term care by changing the way the budget is structured through a global budgeting process

In 1996, New Jersey started reforming its long-term care system with the creation of the DHSS. In state fiscal year (SFY) 1997, 92.7% of public long-term care funds for older adults were spent on nursing homes while 7.3% were spent for HCBS options. In SFY 2002, funding shifted to 84.7% for nursing homes and 15.3% for HCBS care.[21] In SFY 2004, funding shifted to 83.0% for nursing homes and 17.0% for HCBS care.[22]

[21] Senior's Unisys ad hoc reports, A6260R10/15 and SIBA
[22] Senior's Unisys ad hoc reports, A6260R10/15 and SIBA

The numbers of people served in nursing facilities dropped by approximately 2,000 individuals, from almost 32,000 in SFY 1997 to about 30,000 in FY 2004.[23] Concurrently the individuals served by New Jersey's HCBS programs for older adults increased from under 6,000 in SFY 1997 to almost 17,500 in FY 2004.[24]

## OBJECTIVES

Two Executive Orders were issued by former Governor James E. McGreevey and Acting Governor Richard Codey in 2004 and 2005, respectively. These Executive Orders called for the implementation of a global budgeting process. This will enable the development of a long-term care system that is consumer driven, clinically appropriate, cost-effective, and fiscally responsive.

## STRATEGY

1. The market-based approach inherent in global budgeting gives individuals more choice over the location and types of services they receive.

## PERFORMANCE MEASURES

Older adults will be able to make their own long-term care decisions because this will be a system that incorporates the philosophy of consumer direction and individual control in State policies and programs.

## GOAL 7: Continue an open communications framework established within the DACS in order to foster cohesion and efficiency.

## STRATEGY

1. DACS will continue to hold annual meetings for all staff and retreats for managers. It will encourage inter-office collaboration on new initiatives in order to keep staff informed, solicit input on work and service-related issues, identify efficiencies in program administration, and maximize staff resources and development.

## PERFORMANCE MEASURES

DACS will continue to pursue open communications within the Division and between the Division and the AAAs.

[23] Senior's Unisys ad hoc reports, A6260R10/15 and SIBA
[24] Senior's Unisys ad hoc reports, A6260R10/15 and SIBA

## GOAL 8: Transform information technology to support systems change at DACS.

DACS is a product of an internal consolidation of two divisions at DHSS in 2003. Prior to that, all senior services were transferred, consolidated, and reorganized within DHSS in 1996. Current Information Technology (IT) support at DACS is a result of these consolidations; which they took place without an overall systems integration strategy.

### OBJECTIVES

It is this fragmented integrated IT system that is being enhanced to meet with growing collection, monitoring, client assessment, care planning, and care management needs plus payment systems, program data, and provider information. DACS is at the early stages of developing the infrastructure to integrate these client, program, provider, and payment information systems.

### STRATEGY

1. To integrate and maintain the systems, DACS will enhance staff resources through new hires and consultative services. For instance, the ADRC has hired an IT consultant to develop an MIS strategy. Included in the MIS strategy is an examination of the existing data systems, a gap analysis, and the researching of benefits screening, information referral, and resource directory applications, among other activities.

### PERFORMANCE MEASURES

DACS will continue to improve and enhance information technology across all programs and services to advance systems change.

## GOAL 9: Reengineer the Office of Community Choice Options to meet changing needs and business conditions.

In 2004, the Office of Long Term Care Options became the Office of Community Choice Options to emphasize its mission of transitioning individuals from nursing homes to the community. OCCO has been transforming itself in more than name only (see performance measures).

The plan also refocuses the Pre-Admission Screening (PAS) process on meeting the requirements of acute care hospitals to reduce costs by decreasing the patient length of stay and enabling more individuals to benefit from home and community options.

## OBJECTIVES

Since the Office of Community Choice Options performs the clinical eligibility determination for New Jersey's long-term care Medicaid funded programs, the operation of this office is critical to the success of developing a global budget system in New Jersey.

## STRATEGY

1. A consolidation proposal has been approved to reorganize the Office of Community Choice Options into three regions from eight. Each of the three regional offices will be divided into a minimum of two teams with responsibility for a geographic area. The streamlining promotes the values of partnership, client self-determination, and access to services by increasing programmatic efficiency, cost effectiveness, and flexibility to meet the changing needs of seniors, caregivers, and the health care services delivery system.

## PERFORMANCE MEASURES

In CY2003, Community Choice Counselors facilitated the discharge of 206 individuals from nursing homes. In CY2004, there were 258, a 20% increase in one year.

In 2004, Community Choice Counselors completed a total of 33,746 PAS assessments for nursing home or waiver program placement. This represents a 10% increase in PAS completions from 2003 to 2004. Timeliness in completing PAS assessments improved from 55% to 95% in 2004.

## GOAL 10: Develop a formal outcomes measurement model for selected programs in order to document changes in the knowledge, attitudes, behavior, and/or physical and/or emotional well-being of recipients of aging services.

The performance measures delineated throughout this plan generally indicate the degree to which DACS will have performed its role and responsibilities with regard to achieving its objectives. These measures are important for holding DACS accountable for commitments it has made in this plan. They do not, however, directly measure the impact on clients, recipients, and beneficiaries of DACS and/or AAA services.

## OBJECTIVES

As part of its commitment to promote effective and responsive management, DACS will develop a formal outcomes measurement model, including quantifiable indicators, for at least two selected programs.

## STRATEGY

1. DACS will begin this endeavor by selecting at least two programs that lend themselves to outcome measurement. For instance, DACS could focus on the Senior Nutrition program, which currently consists of meals served almost daily at 239 centers throughout New Jersey in a group or congregate setting as well as home delivered meals. DACS would establish pre- and post-intervention evaluation instruments to enable it to document changes occurring directly as a result of these nutrition programs. For instance,

    - Comparison of physical exam results prior to participation in a nutrition program and at periodic intervals following active participation are likely to show improvements in physical well-being.

    - Comparison of responses to questionnaires administered to seniors upon first coming to nutrition centers and at periodic intervals following active participation are likely to indicate improvements in attitude, e.g. seniors may have a more positive outlook on life, a decreased sense of isolation, developing friendships, and the like.

To site an entirely different example, DACS could focus on its Caregiver at Home initiative, in which it provides mental health counseling, professional in-home training and education, and trained volunteer supportive assistance to caregivers. Pre- and post-intervention evaluation could include the following:

- Comparison of responses to questionnaires administered to caregivers prior to and subsequent to their receiving Caregiver at Home services are likely to indicate various improvements in knowledge and attitudes, e.g. caregivers may have more information about where to get needed help, they may have learned specific techniques for handling their frail patient, they may have overcome emotional issues such as loss/denial/depression related to their roles as a caregivers, and the like.

## PERFORMANCE MEASURES

DACS will work with an expert on the development of quantifiable outcomes indicators and pre- and post-intervention evaluation instruments for selected programs. The result will be a formal outcomes measurement model for at least two programs.